

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08277

## CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH: Rabat  
 County: Oxford, Md.  
 City or town: Oxford, Md. (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

3. (a) FULL NAME Etta Bailey  
 4. Sex female 5. Color or race A. A. 6. (a) Single, married, widowed, or divorced married  
 (b) Name of husband or wife Orlando Bailey  
 7. Birth date of deceased (mo., day, yr.) July 10 1917  
 8. AGE: Years 30 Months 2 Days 20 If less than one day  
 hrs. 0 min. 0  
 9. Birthplace Oxford, Md. (Town, county, and state)  
 10. Usual occupation Salazar  
 11. Industry or business Same as above  
 MOTHER FATHER  
 12. Name William E. Anderson  
 13. Birthplace Upper Hill, Md.  
 14. Maiden name Lulu Johnson  
 15. Birthplace Upper Hill, Md.  
 16. Informant Mrs. Lulu Johnson  
 Address Oxford, Md.  
 17. Burial Date thereof OCT 3-47 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Odd Fellows  
 Location Oxford, Md.  
 18. Funeral director James P. Stewart  
 Address Salisbury, Md.  
 19. Oct 1st 1947 Joseph L. Bass (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED: 918  
 (For newborn infants give residence of mother)  
 State Maryland County Oxford, Md.  
 City or town: Oxford, Md. (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 918 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (b) Social Security Number 212-16-4906

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1947, at 5 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Sept 30 1947and that I last saw her alive on Sept 30 1947Immediate cause of death Goutt Endocarditis DURATION 3 weeks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE Howard T. Webb, M.D. M. D. or otherAddress Portney, Md. Date signed Oct 1/47

RECEIVED

OCT 3 1947

STREAP R.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

aen 8.19.47

08278

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County.....

City or town.....

Talbot Co.

Easton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

16 days.

Hospital, Institute, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?.....

16 days.

## 3. (a) FULL NAME

Mr William Banning

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Oct 6/1869

6.(c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

72 10 27

hrs. min.

9. Birthplace.....

(Town, county, and state)

Talbot County

Painter

10. Usual occupation.....

11. Industry or business

MOTHER / FATHER

12. Name.....

Mr James A. Banning

13. Birthplace.....

Linthgow

14. Maiden name.....

Mary Tyler

15. Birthplace.....

England

16. Informant.....

Mr Charles Banning

Address

Linen Mills, Md. (Baptist)

17. (Burial, cremation, or removal, Which?)

Burial 9/5/47

Date thereof (month) (day) (year)

Cemetery or crematory.....

Springfield

Location.....

Baptist

18. Funeral director.....

P. Ellis Clark Esq.

Address

Baptist, Md.

19. (Date rec'd by registrar).....

9/4 1947

(Date rec'd by registrar).....

1947

(Date rec'd by registrar).....

1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept 3

1947 at 5:31 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/19 1947 to 9/1 1947

and that I last saw him alive on 9/1 1947

1947

Immediate cause of death.....

Cerebral apoplexy

DURATION

2 weeks

Due to.....

arteriosclerosis, generalized

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

P. E. C. 29

M. D. or other

Address.....

Easton, Md.

Date signed 9/4/47

66-2176

1947

1947

1947

RECEIVED

SEP 8 1947

BUREAU F B

66-2176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

08279

Reg. Dlat. No. 290

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

City or town Boston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One week

Hospital, Institution, or street address where death occurred:

104 Higgins St., Boston, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

Mable L. Blackwell, Mable L.

4. Sex

F.

5. Color or race

Col'd

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

George Blackwell

6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

July 17, 1907

8. AGE: Years 40 Months 2 Days 4 If less than one day

hrs. min.

9. Birthplace Baltimore City  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Sh. Dorsey

13. Birthplace Baltimore City

14. Maiden name Mary Kellum

15. Birthplace Virginia

16. Informant Sadie D. Wing

Address 104 Higgins St., Boston, Md.

17. Burial Date thereof Sept. 24, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Richards Memorial Park

Location Boston, Maryland

18. Funeral director Leon J. Henry

Address 10 South St., Boston, Md.

19. 9/22 1947

(Date rec'd by registrar) (Date of death) (Year)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore

City or town Boston

(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 Higgins St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

9-21 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-21-1947 to 9-21-1947

and that I last saw her alive on 9-21-1947

Immediate cause of death

Coronary Thrombosis

Due to

Arteriosclerosis

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

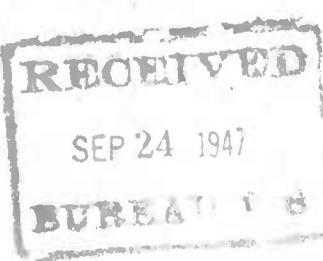
A. M. P. Stevens M.D.

M. D. or other

Address

Easton, Md.

Date signed 9-22-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

## CERTIFICATE OF DEATH

Reg. Dist. No. 08284  
2924

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

Martha Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years      Months      Days      If less than one day

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cemetery or crematory

Location

18. Funeral director

Address

19. (Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 27 1947 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1 1947 to Sept. 27 1947

and that I last saw her alive on Sept. 27 1947

Immediate cause of death

Cerebral Hemorrhage, 1 day

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hayward T. Melt, M.D. M.D. or other

Address Easton, Md. Date signed 9/29/47

RECEIVED

OCT 1 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

08281

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

Talbot County

Kirkham

Easton R.D.

(If outside city or town limits, write RURAL and give nearest town)

15 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edgar Harrison Burns Jr.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M W S

8. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 9th., 1915

8. AGE: Years Months Days If less than one day  
32 8 7 8 hrs. min.9. Birthplace Naugatuck, Conn.  
(Town, county, and state)

10. Usual occupation Broiler raiser

11. Industry or business Poultry business

12. Name Edgar H. Burns Sr.

13. Birthplace St. Michaels, Md.

14. Maiden name Mazie Beatrice Peck

15. Birthplace Naugatuck, Conn.

16. Informant Edgar H. Burns Sr.

Address Easton RFD

17. (Burial, cremation, or removal. Which?) Date thereof Sept. 20, 1947  
(month) (day) (year)

Cemetery or crematory Oliver Cemetery

Location St. Michaels Rd.

18. Funeral director Newnam &amp; Harrison

Address St. Michaels, Md.

19. (Date rec'd by registrar) 9/19/47 N.H. Peeler  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Talbot

City or town Kirkham

Easton R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17th 1947 at 4 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1st 1947 to Sept. 17 1947 and that I last saw him alive on Sept. 16th 1947.

Immediate cause of death

Carcinoma of colon with metastases

DURATION

9 mos.

Due to Recurrence following operation performed May 1942

Due to

Other conditions

(Indicate pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. L. Wilkinson, M.D. or other

5713 Bel Air Rd.

Date signed 9/18/47

Address

Baltimore 6, Md.

RECORDED

SEP 23 1947

BUREAU V 8

1 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

admitia 7-11-47

08282

## CERTIFICATE OF DEATH

93d

Reg. Dist. No.

290

## 1. PLACE OF DEATH:

County..... *Talbot Co.*City or town..... *Easton, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *56 days*

Hospital, Institution or street address where death occurred:

*Monocle Hospital*How long in hospital or institution?..... *56 days*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.*County..... *Talbot*City or town..... *St. Michaels*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## 3. (a) FULL NAME

*Mrs Minnie B. Caulk*

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Female* *white* *Married**Marian B. Caulk*

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

..... *April 20, 1877* years

8. AGE: Years

Months

Days

If less than one day

..... hrs. ..... min.

70

1

9. Birthplace..... *Baltimore, Md.*

(Town, county, and state)

10. Usual occupation..... *H. W.*

11. Industry or business.....

12. Name..... *Mr. John Cullen*13. Birthplace..... *Baltimore, Md.*14. Maiden name..... *Laura Carton*15. Birthplace..... *Baltimore, Md.*16. Informant..... *Daughter, Marian C. Hiel*17. Address..... *Aurora St., Easton, Md.*18. Burial..... *Clint Cemetery*

(Burial, cremation, or removal. Which?)

Date thereof..... *Sept. 6, 1947*

(month) (day) (year)

Cemetery or crematory..... *Clint Cemetery*19. Location..... *St. Michaels, Md.*20. Funeral director..... *Neuman & Garrison*Address..... *St. Michaels, Md.*21. (Date rec'd by registrar) *9/5*(Date of death) *1947*(Name of physician) *N. H. Neuman*22. Registrar..... *Registrar*

## MEDICAL CERTIFICATION

20. DATE OF DEATH

9-4 1947 at 7:00m M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1947 to September 4 1947 and that I last saw her alive on September 4 1947

Immediate cause of death.....

*Pt. post partum embolism with sepsis*Due to..... *Congestive Heart Failure*Due to..... *Hypertension*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

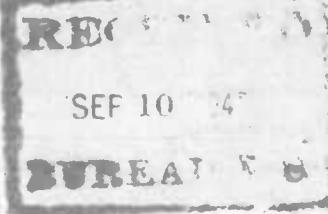
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *M. M. Palmer*

M. D. or other

Address..... *Easton, Md.*Date signed *Sept. 14, 1947*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Pascal

08283  
932

Reg. Dist. No. 290

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years      Months      Days      If less than one day

97-

16

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him/her alive on

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

24. M. D. or other

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 1- 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 23 1947 to Sept 1 1947

and that I last saw him/her alive on August 31 1947

Immediate cause of death

Cancer Schistos. heart disease

DURATION

year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. F. Burch

M. D. or other

Date signed

RECEIVED

SEP 8 1947

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08284

## CERTIFICATE OF DEATH

93d  
Reg. Dist. No.

290

## 1. PLACE OF DEATH:

County TalbotCity or town Cordova Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ROSETTA DOBSON

4. Sex

Female

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.)

Years

Months

Date

6. (c) If alive, give age

years

1873 July 7, 1873

If less than one day

hrs. min.

8. AGE:

74

9

9

2

7

9. Birthplace Cordova Talbot Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name JERRY BAILEY13. Birthplace Unknown14. Maiden name Lizzie Madden15. Birthplace Unknown16. Informant George DobsonAddress Talbot Md.17. Burial Burial Date thereof 9/14/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Chapel CemeteryLocation Cordova Talbot Md.18. Funeral director Carl W. StiffordAddress Easton Md19. (Date rec'd by registrar) 9/14/47 (month) (day) (year)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty TalbotCity or town Cordova

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept. 11 1947

19

at

6

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 to Sept. 11 1947

19

to

19

and that I last saw her alive on Sept. 9, 1947Immediate cause of death itis and myocardialdiseases Due to arteriosclerosisDue to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

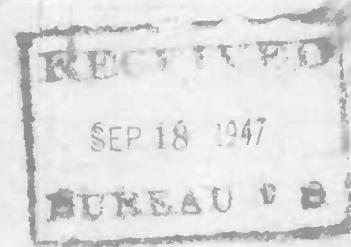
Karl Lederer M.D.

M. D. or other

Address Area 400 41st St. Date signed 9/12/47

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MITARU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195e (146e) 08285

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH

County Salisbury Co.City or town Easton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days.Hospital, institution, or street address where death occurred: Memorial Hospital, Easton, Md.How long in hospital or institution? 61 days.

## 3. (a) FULL NAME

Oscar Flamer.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Black. Married.6. (b) Name of husband or wife Clifford Flamer6. (c) If alive, give age 38 years7. Birth date of deceased (mo., day, yr.) Aug. 27, 19078. AGE: Years 40 Months 17 Days 17 If less than one day hrs. min.9. Birthplace Salisbury Co. (Town, county, and state)10. Usual occupation House wife

## 11. Industry or business

12. Name Robert R. Lewis13. Birthplace Salisbury Co.14. Maiden name Sarah Elizabeth Blake15. Birthplace Salisbury Co.16. Informant Clifford FlamerAddress 3 Miles River - P.F.D. 1, Md.17. 9/14/47 (Burial, cremation, or removal? Which?) Date thereof Aug. 24 (month) (day) (year)Cemetery or crematory CoopervilleLocation Salisbury, Md. R.D. 116. Funeral director Leon W. HenryAddress 310 South St. Easton18. 9/14 (Date rec'd by registrar) 1947 11:30 P.M. (Time)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SalisburyCity or town Easton (If outside city or town limits, write RURAL and give nearest town)Street No. P.F.D. #1

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 - 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 24 1947 to Sept. 13 1947 and that I last saw her alive on Sept. 13, 1947.

Immediate cause of death

Peritonitis, acute

DURATION

10 daysDue to perforated Hollow viscera11 days ago

Due to

Other conditions Uremia2 daysPregnancy, full term  
(Include pregnancy within 3 months of death)• Major findings of operations Retained placental  
tissue, chronic cervicitis Date of op. Aug. 28, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

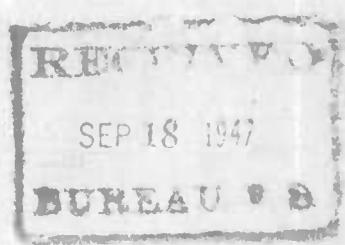
Means of injury

Injured at work?

23. SIGNATURE James Flamer

M. D. or other

Address 213 Church St. Easton, Md. Date signed Sept. 13, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

200a

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH: Talbot  
 County .....  
 City or town ..... St. Michaels, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lydia F. Ford

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widow

6. (b) Name of husband or wife ..... R. Lee Ford.

7. Birth date of deceased (mo., day, yr.) Dec 24, 1864

6. (c) If alive, give age ..... years

8. AGE:	Years	Months	Days	It less than one day
	82	8	28	hrs. ..... min.

9. Birthplace ..... Bay Hundred, Talbot Co., Md. (Town, county, and state)

10. Usual occupation ..... Housewife

## 11. Industry or business

12. Name ..... Edward N. Lomax

13. Birthplace Bay Hundred, Talbot, Md.

14. Maiden name ..... Francis Ann Hussey

15. Birthplace Baltimore, Md.

16. Informant ..... Mrs. Harry Mervine

Address ..... St. Michaels, Md.

17. Burial ..... Cemetery

Date thereof ..... Sept. 22 1947  
 (Burial, cremation, or removal. Which?)

Location ..... Near Sherwood, Maryland

18. Funeral director ..... Newnam & Harrison

Address ..... St. Michaels, Maryland

19. Sept. 22 1947  
 (Date rec'd by registrar) *Mrs. Robert L. Leeks*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State	Md.	County	Talbot
City or town	St. Michaels, Md.	(If outside city or town limits, write RURAL and give nearest town)	
Street No.			

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (b) Social Security Number ..... none

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... 20 September 1947, at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dead on arrival*, 1947, to 20 Sept 1947

and that I last saw her alive on 1947.

Immediate cause of death ..... Heart Failure

DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op.

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

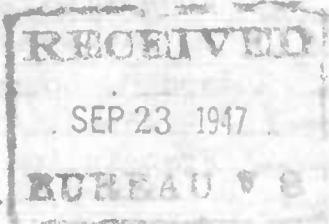
Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

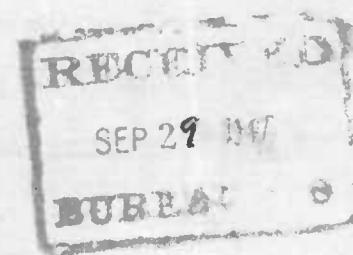
23. SIGNATURE ..... *Herbert Morrison*

M. D. or other

Address ..... St. Michaels, Maryland Date signed ..... 23 Sept 1947







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

08288  
290

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Laura Jenkins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

Col. Widowed

Joyce

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

April 27 - 1870

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Caroline Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

No Record

13. Birthplace

No Record

14. Maiden name

Eva Driver

15. Birthplace

Caroline Co. Md.

16. Informant

Lola Cooper

Address

Easton Rural Md.

17. Burial

Burial, cremation, or removal? Date thereof

(month) (day) (year)

Cemetery or crematory

Hamontown

Location

Easton, Md.

18. Funeral director

P. B. Rawlings

Address

Greensboro Md.

19. Date rec'd by Registrar

7/23 - 1947 N. H. Peers

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born Infants give residence of mother)

State Maryland

County

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 22 1947 at 1055 P.M.

21. I CERTIFY that death occurred on the date above stated: that attended deceased from

Sept 18 1947 to Sept 22 1947

and that I last saw her alive on Sept 21 1947

Immediate cause of death

Myocardial failure

DURATION

3 mo

Due to Generalized arteriosclerosis over 15 yr.

Due to

Inflammation &amp; decubitus over 6 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

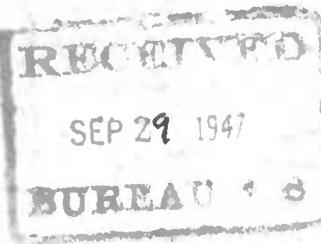
Injured at work?

23. SIGNATURE

Charles Wayman MD

M. D. or other

Address Masonic Bldg - Easton, Md. Date signed 7/23/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Sr. Cox

08289

290

Reg. Dist. No. 290

1. PLACE OF DEATH: Easton Rural  
 County Rural  
 City or town Easton (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr.  
 Hospital, institution, or street address where death occurred: Easton

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Bella Gertrude Jones7. Birth date of deceased (mo., day, yr.) Feb. 16, 1887 6. (c) If alive, give age years8. AGE: Years 60 Months 6 Days 28 It less than one day 7 hrs. 0 min.9. Birthplace Easton Md. (Town, county, and state)10. Usual occupation Farming11. Industry or business Theodore Jones12. Name Theodore Jones13. Birthplace Md.14. Maiden name Mary Kirby15. Birthplace Md.16. Informant Mrs. Hilda ParrottAddress Blford Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof Sept. 17, 1947Cemetery or crematory Young HillLocation Easton Md.18. Funeral director Elmer ClarkAddress Easton19. (Date rec'd by registrar) 9/13/47 19 47 N.H. Nease Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Easton  
 City or town Easton (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 19 47 at 6 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1, 19 47, to Sept. 14, 19 47 and that I last saw him alive on Sept. 7, 19 47

Immediate cause of death

Carcinoma of Prostate  
metastasis to spine &  
fever

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

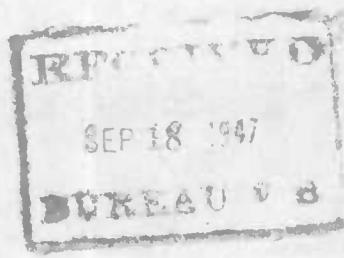
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elmer Clark M. D. or otherAddress Easton Md. Date signed 9/15/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08290

Reg. Dist. No. 291

1. PLACE OF DEATH: Talbot  
County: St. Michaels, Md.  
City or town: (If outside city or town limits, write RURAL and give nearest town) Life

How long in above place of death?:  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

## 3. (a) FULL NAME

Maude Keithley

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	Single

8. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) August 3rd 1881

8. AGE: 66 Years	Months 1	Days 27	If less than one day
			hrs. min.

9. Birthplace: St. Michaels, Talbot Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER: Charles S. Keithley  
12. Name: St. Michaels, Talbot Co.

MOTHER: Sarah E. Pritchard  
13. Name: Baltimore, Maryland.

14. Maiden name: Baltimore, Maryland.

15. Birthplace: Baltimore, Maryland.

16. Informant: Mrs. Ralph J. Martin.

Address: St. Michaels, Maryland.

Burial Date thereof: Oct 2, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Olivet Cemetery

Location: St. Michaels, Maryland.

18. Funeral director: Newnam &amp; Harrison

Address: St. Michaels, Maryland.

19. Date fee'd by registrar: 10/1/1947

Name: Mrs. Bolt, Ruth

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot  
City or town: St. Michaels (If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number  
None

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1947 19 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11, 1947 19 to Sept. 30, 1947 19 and that I last saw her alive on Sept. 27, 1947 19.

Immediate cause of death: Uremia (acute)

Arteriosclerotic Nephritis

DURATION

Due to:

Due to:

Other conditions:

Hypertension

Rheumatoid Arthritis

(Include pregnancy within 8 months of death)

Over 2

Yrs.

Major findings of operations: None

Date of op.:

None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of: ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ✓ Injured at work? ✓

23. SIGNATURE:

St. Michaels, Md.

Address: M. P. 10/1/47 Date signed:

RECEIVED

OCT 3 1947

BTP



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

## CERTIFICATE OF DEATH

08291

Reg. Dist. No.

290

## 1. PLACE OF DEATH:

City or town

State

*Tolbot*  
*Easton (Hospital)*

(If outside city or town limits, write RURAL and give nearest town)

*a few hours*

Along in above place of death?

Hospital, institution, or street address where death occurred:

*Easton Memorial Hospital*  
*a few hours*

How long in hospital or institution?

## 3. (a) FULL NAME

*George Rutherford Dawson*

4. Sex

Male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

*Dec. 18, 1914*

8. AGE:

Years  
32Months  
8Days  
25

If less than one day

hrs.

min.

9. Birthplace

*Virginia*

(Town, county, and state)

10. Usual occupation

*Labored*

11. Industry or business

*Rutherford Dawson*

12. Name

Father

13. Birthplace

*W. Va.*

14. Maiden name

*Willie Ford*

15. Birthplace

*N. Carolina*

16. Informant

*E. H. Coprue*

Address

*905 Glasgow St. Portsmouth, Va.*

17. Ship

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory *Coprue Funeral Home*

Location

*Portsmouth, Va. 905 Glasgow St.*

18. Funeral director

*John D. Williams*

Address

*Easton, Md.*

19. (Date rec'd by registrar)

*9/8**19. 47*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MD*

County

*Anne Arundel*City or town *Wilmington*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Sept. 7*

19. 47

al

*7.38 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 10.

19.

and that I last saw him alive on

Immediate cause of death *From loss of blood & shock*

DURATION

Due to *The was cut in a fight artery in leg was cut - the*or *bleed*Due to *falling while enroute to hospital -*

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

*Homicide?* Date of

Where did injury occur?

*Wilmington - 2 a*

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

*Cut in a fight*

Injured at work?

23. SIGNATURE

*W. J. Brown, Fishers, Md.*

(Duly sworn and true as far as I know)

M. D. or other

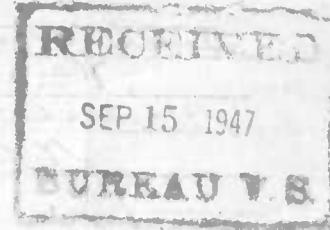
Address

*Portsmouth, Md.*

Date signed

*9/7/47*

"The woman that cut him is in jail on a homicide charge."  
Dr. Asher - 10/22/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08292

131a

## CERTIFICATE OF DEATH

Reg. Dia. No. 290

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years      Months      Days      If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

(Date of death)

19. (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2, 1947 to Sept. 20, 1947

and that I last saw her alive on Sept. 15, 1947

Immediate cause of death

Acute Uremia

DURATION

Over 3 yrs

Due to Arteriosclerotic Nephritis

Hypertension

Other conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. ✓

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

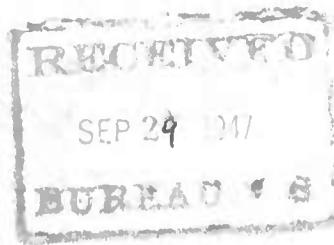
Means of Injury Injured at work? ✓

23. SIGNATURE

St. Michaels, Md.

M. D. or other

Date signed 9.22.47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

## CERTIFICATE OF DEATH

Reg. Dist. No. 08290

## 1. PLACE OF DEATH:

County WaldorfCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 10 days

## 3. (a) FULL NAME

Massey, Lydia4. Sex Female 5. Color or race N 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.) April 3, 1903 8. (c) If alive, give age ..... years8. AGE: Years 44 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Queen Anne County (Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name William Massey13. Birthplace Queen Anne County14. Maiden name Emma A. Elliott15. Birthplace Queen Anne County16. Informant Memorial Hospital recordsAddress Easton Md.17. (Burial, cremation, or removal. Which?) Burial Date thereof 10/15/47 (month) (day) (year)Cemetery or crematory Port of Easton MdLocation Port of Easton Md18. Funeral director Calmie ClarkAddress 102 40 Green St Easton Md.19. (Date rec'd by registrar) 9/15/47 N.H. Nease Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For birth, parents give residence of mother)

State DelCounty DoverCity or town Dover - RD (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1947, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death

Cerebral hemorrhage  
right

Due to.....

Due to.....

Other conditions Fibroid uterus  
large

(Include pregnancy within 8 months of death)

Major findings or operations 10 lb. fibroid removed Date of op. 9/4/47Autopsy results not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE J.T.B. Ambler M.D. M. D. or otherAddress Easton Md. Date signed 9/15/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

08294

## CERTIFICATE OF DEATH

Reg. Dist. No. 275

## 1. PLACE OF DEATH:

County

Talbot

City or town

Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Lifetime

Hospital, institution, or street address where death occurred:

6 South St.

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Edmund Morris

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

8. (b) Name of husband or wife

Emma Morris Morris

7. Birth date of deceased (mo., day, yr.)

March 30, 1860

6. (c) If alive, give age 70 years

8. AGE:

Years Months Days If less than one day

87 5 12 hrs. min.

8. Birthplace

Easton, Talbot, Maryland

(Town, county, and state)

10. Usual occupation

Newspaper editor

11. Industry or business

Jeremiah Morris

12. Name

Easton, Maryland

13. Birthplace

Sarah Virginia Leonard

14. Maiden name

Easton, Maryland

15. Birthplace

Margaret V. Morris

16. Informant

Easton, Maryland

Address

Burial

Date thereof: Sept 13, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Springfield

Location

Easton Md

18. Funeral director

J. W. &amp; W. Morris &amp; Son

Address

Easton Md

19. Date record by registrar

9-1-2-1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 South Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 11 1947 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1947 to Sept 11 1947 and that I last saw him alive on Sept 11 1947

Immediate cause of death

Carcinoma of Prostate

Due to

Due to

Other conditions

Metastasis to Liver, Ductal Tract

(Include pregnancy within 8 months of death)

Major findings of operations

700

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

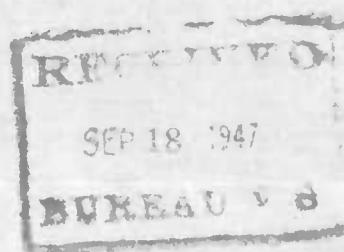
23. SIGNATURE

G. W. C. Stevens M.D.

M. D. or other

Address Easton Md

Date signed 9-12-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08295

## CERTIFICATE OF DEATH

Reg. Dist. No.

291

## 1. PLACE OF DEATH:

County.....

Talbot

City or town.....

Newcomb

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

For sever

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

James A. Neonom

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Cornelia Neonom

7. Birth date of

deceased (mo., day, yr.)

1-10-1877

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

70

8

6

hrs.

min.

9. Birthplace.....

Royal Oak Talbot Co Md

(Town, county, and state)

10. Usual occupation.....

Waterman

11. Industry or business

Oyster

12. Name.....

William Neonom

13. Birthplace

Royal Oak

14. Maiden name.....

Mary Harriman

15. Birthplace

Royal Oak

16. Informant.....

Mrs Martin Cummings

Address.....

Easton, Md.

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

9-17-47

Cemetery or crematory.....

Olivet

Location.....

St. Michaels Md.

18. Funeral director.....

J. Neonom Marshall

Address.....

St. Michaels Maryland

19. Date rec'd by registrar

Sept 16, 1947

Mr. Bob L. Self

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Talbot

City or town.....

Newcomb

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

12:30 a.m.

20. DATE OF DEATH.....

Sept 16, 1947

19

at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 20, 1947

19

to

Sept. 15, 1947

19

and that I last saw him.....alive on

Sept. 15, 1947

19

Immediate cause of death.....

Coronary Disease

DURATION

Due to.....

Arteriosclerosis

&amp; Hypertension

Due to.....

Other conditions.....

None

Over

2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

None

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

y 326

Injured at work?

23. SIGNATURE

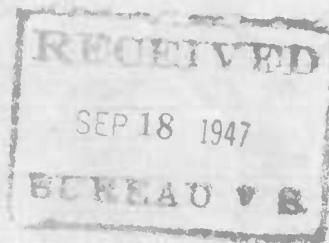
M. D. or other

Address.....

St. Michaels, Md.

Date signed.....

9-16-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08296

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 61  
CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County.....

Faelt

City or town.....

Easton - md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

7 day

Hospital, institution, or street address where death occurred:

Memorial Hospital - Easton, md.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mr. Stanley Reid

4. Sex

5. Color or race

male White married

## 6. (b) Name of husband or wife

Mr. Chester Reid

7. Birth date of deceased (mo., day, yr.)

July 8, 1877

B. (c) If alive, give age 81 years

8. AGE:

Years

Months

Days

If less than one day

70

2

1

hrs.

min.

9. Birthplace.....

Talbot Co.

(Town, county, and state)

10. Usual occupation.....

Farmer

## 11. Industry or business

Mr. Wm Reid

FATHER

12. Name.....

13. Birthplace

14. Maiden name.....

15. Birthplace

16. Informant.....

Address.....

17. (Burial, cremation, or removal, which?)

Date thereof.....

(month)

(day)

(year)

Cemetery or premises.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

Date.....

19. (Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Talbot (If outside city or town limits, write RURAL and give nearest town)

Street No.....

Bural

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 9 1947 at 4 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to Sept 9 1947

and that I last saw him alive on Sept 9 1947

Immediate cause of death.....

Coronary Thrombosis

Due to.....

Due to.....

Other conditions.....

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?.....

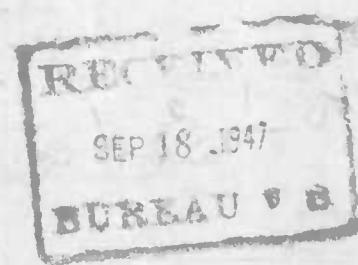
23. SIGNATURE.....

M. D. or other

Address.....

Date signed 9-10-47

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

P8297  
290

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

Talbot

Easton, Maryland

How long in above place of death

Hospital, Institution, or street address where death occurred:

20 years

How long in hospital or institution?

## 3. (a) FULL NAME

Emaline Catherine Ross

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

7

Col 4

Widow

6. (b) Name of husband or wife

John Ross

6. (c) If alive, gives age years

7. Birth date of deceased (mo., day, yr.)

March 4, 1864

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Trappe, Talbot Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Green Camper

13. Birthplace

Talbot County

14. Maiden name

Emaline Camper

15. Birthplace

Talbot County

16. Informant

Blanche Ross

Address

Flood Lane

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

9/8/47

Cemetery or crematory

Trappe, Md.

Location

Trappe, Maryland

18. Funeral director

Leon W. Henry

Address

310 South St. Easton, Md.

19. 9/6

19 47

11:45 P.M.

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Easton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Flood Lane

(If rural, give LOCATION)

2. (d) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 4, 1947, at 11:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1

1946, to Sept 4, 1947

and that I last saw her alive on

Sept 3, 1947

Immediate cause of death

Art. A. Ch. Heart disease

DURATION

6 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

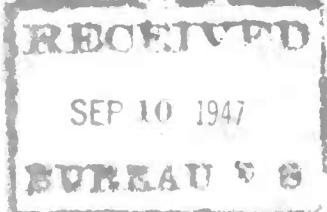
23. SIGNATURE

L. J. Burchell

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9-6-47  
309  
08298

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

Talbot

City or town

Frost

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

18 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

18 days Shrs.

## 3. (a) FULL NAME

Sharp Mary

4. Sex

Female

5. Color or race

Negro

6.(a)

Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Artie Sharp (husb)

7. Birth date of deceased (mo., day, yr.)

July 5, 1895

6.(c) If alive, give age years

8. AGE:

52

Years

Months

Days

If less than one day

3 10

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

Housework

10. Usual occupation

11. Industry or business

George Charles

FATHER

12. Name

John Cayland

MOTHER

13. Birthplace

Rebecca Charles

14. Maiden name

John Cayland

15. Birthplace

Artie Sharp

16. Informant

Bethlehem Md

Address

Burial

Date thereof 9/29/47

(Burial, removal, removal, removal)

(month)

(day)

(year)

Cemetery or crematory

Mt Pleasant

Location

near Preston Md

18. Funeral director

J. Frankton Son.

Address

Federally Md.

19. (Date read by registrar)

9/25/47

19.

M. H. Neeress

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Caroline

City or town

Preston

R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

9-25-

1947 al 5<sup>10</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

days

6

1947, to 9-24

1947

and then last saw her alive on

9/24/47

1947

Immediate cause of death

Chronic interstitial Nephritis

DURATION

1 yr?

Due to

Due to

Other conditions

Tertiary Tires

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

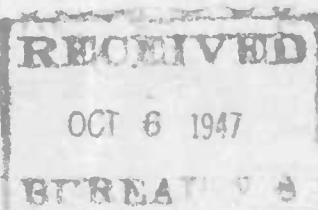
B. Cox M.D.

M. D. or other

Address

Eaton Md

Date signed 9/1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08299

## CERTIFICATE OF DEATH

Reg. Dist. No. 297

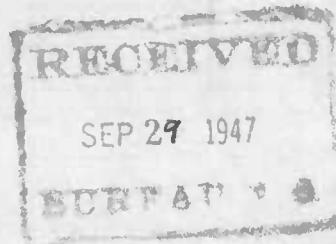
1. PLACE OF DEATH: Talbot  
 County: Oxford  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: Md County: Talbot  
 City or town: Oxford  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.:  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war:

3. (a) FULL NAME: Strawberry Lee Willey  
 4. Sex: Male 5. Color or race: white 6.(a) Single, married, widowed, or divorced: Married  
 6.(b) Name of husband or wife: Maggie G. Willey  
 7. Birth date of deceased (mo., day, yr.): Dec. 25, 1870 8.(c) If alive, give age: 72 years  
 8. AGE: 76 Years 9 Months 1 Days It less than one day hrs.  min.  
 9. Birthplace: Dorchester Co., Md.  
 (Town, county, and state)  
 10. Usual occupation: Waitress  
 11. Industry or business: George St. Wallen  
 MOTHER FATHER  
 12. Name: George St. Wallen  
 13. Birthplace: Dorchester Co. Md.  
 14. Maiden name: Laurena  
 15. Birthplace: Dorchester Co. Md.  
 18. Informant: Mr. Lee Willey  
 Address: Oxford, Md.  
 17. Burial: Oxford Date thereof: Sept. 29, 1947  
 (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)  
 Cemetery or crematory: Oxford  
 Location: Oxford Maryland  
 18. Funeral director: Maurice L. Thompson Son: Don  
 Address: Easton Md.  
 19. Sept. 27 1947 Josie A. Ross Registrar  
 (Date read by registrar) (Signature) (Title)

3. (b) Social Security Number: None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Sept. 26 1947 at \_\_\_\_\_  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 \_\_\_\_\_ to \_\_\_\_\_, 1947, and that I last saw him alive on \_\_\_\_\_, 1947.  
 Immediate cause of death: Cardiac decompensation Duration: 18 min.  
 Due to: Chronic myocarditis 3 years  
 Due to: \_\_\_\_\_  
 Other conditions: \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations: \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results: \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?): \_\_\_\_\_  
 Means of injury: \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE: Josie A. Ross M. D. or other: Graphite  
 Address: \_\_\_\_\_ Date signed: Sept. 27, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

08300

Reg. Dist. No. 290

1. PLACE OF DEATH: Palliat  
 County Easton R.F.D.  
 City or town Easton R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

3. (a) FULL NAME Ella Williams  
 4. Sex Female 5. Color or race A. A. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife John Williams  
 Deceased 6 Dec 6. (c) If alive, give age no years  
 7. Birth date of deceased (mo., day, yr.) about 1885  
 8. AGE: 61 Years about Months — Days — If less than one day hrs. — min.  
 9. Birthplace Gardiner near Easton md  
 (Town, county, and state)  
 10. Usual occupation House Keeping  
 11. Industry or business Same as above  
 FATHER Reuben Walker  
 12. Name Reuben Walker  
 13. Birthplace Gardiner md  
 MOTHER Eva Harris  
 14. Maiden name Eva Harris  
 15. Birthplace Gardiner md  
 16. Informant Perry Walker  
 Address Easton md  
 17. Burial Burial Date thereof Sept 6-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Old Belfree  
 Location near Easton  
 18. Funeral director James H. Stewart  
 Address Salisbury 2nd  
 19. 9/4 1947 M. H. Dever  
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MD County Pellet  
 City or town Easton md R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no  
 3. (b) Social Security Number no

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 1 1947 at 10:30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 1946 to Sept. 1 1947 and that I last saw her alive on Sept. 1 1947

Immediate cause of death Cerebral hemorrhage DURATION 4 days  
 Due to Hypertension DURATION 2-3 years

Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  
 Injured at work?

23. SIGNATURE Hayward T. Welt M.D. M. D. or other

Address Easton, MD Date signed 9/3/47

